

Associated Plastic Surgeons, S.C.  
Otto J. Placik, M.D., F.A.C.S.  
880 West Central Road, Suite 3100, Arlington Heights, IL. 60005

**We are pleased that you are considering us for your plastic surgery.**

**Important issues to consider are;**

- 1.) Will you be coming in for a pre-operative visit prior to your surgery?
- 2.) Will you desire a one-time visit with a consultation and surgery held on the same day?
- 3.) Will someone be accompanying you?
- 4.) Will you have transportation?
- 5.) What are your plans for post-operative care?
- 6.) Will you be staying at our recovery facility or a hotel?

**If you wish to proceed, we respectfully request that you complete our Out-of-Town Consent Packet, which will include the following:**

- 1.) General Out of Town Form
- 2.) Intake Form
- 3.) Health History
- 4.) Elective Surgery Financial Agreement
- 5.) Medical Information Authorization/Insurance Payment
- 6.) Photo Consent

**Please contact our Patient Coordinator to obtain the remaining forms,**

- 7.) Mutual Agreement to Maintain Privacy
- 8.) Consent for Surgery/Procedure or Treatment
- 9.) Medications to Avoid
- 10.) Instructions for Surgery
- 11.) Restrictions after Surgery
- 12.) Prescriptions for Surgery

**\*\*ALL FORMS MUST BE INITIALED AND SIGNED\*\***

**Thank You,**

The Staff of Associated Plastic Surgeons  
880 W. Central Rd. Ste 3100  
Arlington Heights, IL 60005  
847-398-1660  
<http://www.bodysculptor.com/>

General Out of Town Form

Associated Plastic Surgeons, S.C.  
Otto J. Placik, M.D., F.A.C.S.

880 West Central Road, Suite 3100, Arlington Heights, IL. 60005

Since it is difficult for patients to describe what Dr. Placik will see at the time of your consultation, we do request that you send photos of the general area of concern. If you are unable to do so, please contact our office.

\*These photos/digital images **WILL NOT** be released on electronic digital networks, television, patient education, lay publications, or for the purpose of medical education. They are for consultative use only between the patient and our offices, unless authorized by the patient.

**\*\*ANY VERBAL FEES GIVEN BEFORE YOUR CONSULTATION ARE AN ESTIMATE ONLY AND ARE SUBJECT TO CHANGE UPON CONSULTATION\*\***

When you make a commitment to a surgery date, other patients lose the opportunity of scheduling that date, the doctor makes a commitment to you for this time, special garments and implants have been ordered, and arrangements are made with nursing and anesthesia personnel to work on that date. In order to reserve a date for your procedure, we ask that you pay a \$500.00 non-refundable "reservation fee". Full payment is due four weeks prior ("closing date") to the procedure in order to confirm the reserved time slot. If your desired surgery date is earlier than four weeks, we will require full payment at the time of schedule. It is possible that despite the best efforts on Dr. Placik's part, he may decide surgery is not indicated, not in your best interest, or needs to be delayed, etc. In this event up to 50% of surgical fees may be withheld in accordance with the elective financial agreement.

\*Please call or refer to the elective surgery financial agreement under patient forms if you have further questions- <http://www.bodysculptor.com/index.html>

Various surgical procedures will require you to have assistance in the early stages of your post-op. It is important for you to have a companion at the time of discharge. In this instance, we prescribe medications for pain relief or relaxation, a driver is mandatory. If this is not an option; please contact our office and we can make proper arrangements for you.

In the event that symptoms of an emergent nature occur such as severe pain, shortness of breath, hematoma, seroma, high fever, etc...occur you will need to seek immediate treatment at your local medical facility which may generate additional fees. Though patients are welcomed to return for follow-up at 3 months and yearly, the reality of travel over great distance seldom occurs.

In the meantime, if you have any questions at all, please feel free to call us at (847) 398-1660. The entire office is dedicated to giving you the best care available.

Please fill and sign all attached forms including this form, and mail back to us as soon as possible.

**Patient or Person Authorized to Sign for Patient:**

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

Associated Plastic Surgeons, S.C.  
Otto J. Placik, M.D., F.A.C.S.

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
(first) (middle) (last)

Address \_\_\_\_\_ Work Phone \_\_\_\_\_ ext \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Employer/School \_\_\_\_\_ Social Sec. # \_\_\_\_\_

Email Address \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

Referred By:  Doctor \_\_\_\_\_  Hospital \_\_\_\_\_  
 Previous Patient (name) \_\_\_\_\_  Telephone Book \_\_\_\_\_  
 Internet (site) \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext \_\_\_\_\_

Address \_\_\_\_\_

Has this office ever seen or treated any member of your family? Yes \_\_\_ No

If yes, whom? \_\_\_\_\_ (name & relationship)

Emergency Contact \_\_\_\_\_ Home Phone # \_\_\_\_\_  
(not living with patient)

Relationship \_\_\_\_\_ Alternate Phone # \_\_\_\_\_

**\*\* PLEASE PROVIDE YOUR INSURANCE CARD(S) FOR PHOTOCOPYING PURPOSES \*\*\***  
**(NON- COSMETIC PATIENTS ONLY)**

Insurance Company \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insured Party \_\_\_\_\_ Insured Party \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Insurance Plan Yes \_\_\_ No \_\_\_ Employer Insurance Plan Yes \_\_\_ No

PERSON Financially Responsible (other than patient):  Spouse  Parent  Other

Name \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

FIRST VISIT: Complete all sections EXCEPT shaded boxes.

PRE OP: Update form, complete shaded boxes & sign at bottom.

Patient's full name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female

Stated Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Stable:  No  Yes

Exercise:  No  Yes Describe: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

PRESENT PROBLEM/CONCERN, WHICH BRINGS YOU HERE?

Have you consulted with other physicians?:  No  Yes:

Personal physician's name: \_\_\_\_\_

If yes, their names: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Interview via:  Intake History  Phone  Prior to surgery

Source: \_\_\_\_\_

PAST/PRESENT SERIOUS ILLNESSES

Table with 3 columns: Illness, Yes, No. Rows include Heart disease, Blood pressure disorder, Mitral Valve Prolapse, Rheumatic fever, Irregular heart beat, Pacemaker, Chest pain/pressure, Lung disease, Asthma/Wheezing, Emphysema/Bronchitis, Tuberculosis, GI disease, Ulcers/Reflux/Hiatal hernia, Liver disease, Hepatitis, HIV/AIDS, Total joint surgery, Arthritis, Jaw/Neck/Back pain, Poor wound healing, Parkinson's disease, Multiple Sclerosis, Motion sickness, Stroke, Seizure disorder, Severe headaches, Psychologic disease, Special needs/communication, Glaucoma, Corneal Abrasions, Dry Eyes Syndrome, Thyroid disease, Kidney disease, Diabetes, Cancer, Blood clots, Bleeding or bruising problems, Blood transfusions, Anemia, Sleep apnea, Other Illness/Injury, Cold in last 2 weeks? DATE: \_\_\_\_\_

Comments: \_\_\_\_\_

PREVIOUS SURGERY & ANESTHESIA:  No  Yes (include ALL COSMETIC / PLASTIC SURGERY PROCEDURES):

Table with 4 columns: SURGERY TYPE, DATE OF SURGERY, TYPE OF ANESTHESIA, ANESTHESIA PROBLEMS. Rows 1-4.

Table with 2 columns: NAMES OF DAILY HOME MEDICATIONS (include Birth Control Pills), HERBAL MEDS / VITAMIN & DIETARY SUPPLEMENTS. Rows 1-4.

Aspirin / NSAIDS (Motrin/ Advil) / Coumadin:  No  Yes Last Taken: \_\_\_\_\_

Steroids in last 6 months?  No  Yes

Table with 6 columns: HABITS, NEVER, FREQUENCY daily use, # YEARS, DATE LAST USED, ABUSE/INTERVENTIONS?. Rows for Tobacco, Alcohol, Caffeine, Drugs Used.

FEMALES: # Pregnancies: \_\_\_\_\_ # Children: \_\_\_\_\_ Average weight gain: \_\_\_\_\_ or Anticipated pregnancy?  No  Yes

Could you be pregnant?  No  Yes Date of last menstrual period: \_\_\_\_\_

ALLERGIES:  No  Yes (include food & latex & tape, list; if yes, describe reaction): \_\_\_\_\_

\*\*\* Distinguish ALLERGY (shock, hives & throat swelling) from ADVERSE REACTION (nausea & stomach upset) \*\*\*

Patient/Guardian (initials): \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian (initials): \_\_\_\_\_ Date: \_\_\_\_\_

## THIS MUST BE SIGNED TO RECEIVE A WRITTEN QUOTE

### ELECTIVE SURGERY FINANCIAL AGREEMENT

Many factors combine to determine the ultimate outcome with elective cosmetic surgical procedures. The exact same technical procedure performed on ten different patients will yield ten slightly different outcomes. This is because each person is genetically different, heals differently, has different skin tone, bruises differently, and procedures are tailored to you as an individual. I have tried to be as honest as possible in order to paint the average postoperative case scenario and outcome with your procedure. **The need to perform minor revisions or touch-ups is infrequent but possible. In the event that this is necessary in the postoperative period the following will apply:**

- 1). Any revisions performed under local anesthesia or minor sedation administered by the surgeon in an office-based setting will be done at a minimal charge to cover for supplies. The surgeon has to agree that the revision will improve the patient's concern.
- 2). Any revisions or secondary procedures performed that require nursing support and a certified nurse anesthetist, anesthesiologist or certified surgical technician will be charged no surgeon's fee but will incur the minimum cost (**anesthesia/facility**) related to their revision procedure. In general, as these more major revisions will not be performed until six to nine months post-operatively, the surgeon has to agree that the revision will improve the patient's concern. After fourteen months a minimal surgeon's fee may apply.
- 3). If the patient and surgeon are satisfied that the original operation met the planned goals, but the patient wants further improvement then this constitutes a new procedure.

Examples are:

- A). Wanting to further increase breast size nine months after the initial breast augmentation.
- B). With liposuction procedures, any revision due to weight gain over the baseline pre-operative weight constitutes a new procedure in the same anatomic location.
- C). Getting significant shape and contour improvements with liposuction and eight months after working out with weight loss wanting more muscle definition or shape to be evident.
- D). The surgeon has to agree that further surgery will again help the patient with minimal risks.

**A minimal surgeon's fee may apply, however the standard rates for anesthesia and facility will apply**

- 4) **BREAST/ IMPLANT SURGERY:** In order to ensure that all arrangements are set in advance of your surgical Procedure, we require that breast and other implants be ordered two (2) weeks prior to your surgery date. Any changes within the two (2) week deadline necessitate RUSH shipping charges as well as staff time, and therefore will incur a **\$50.00 restocking fee.**

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**ELECTIVE SURGERY FINANCIAL AGREEMENT**

On occasion the best made plans have to be changed. I understand this and will always work with you if you need to cancel surgery unexpectedly. However, if you cancel without good cause, a penalty will apply. **When you make a commitment to a surgery date, other patients lose the opportunity of scheduling that date, the doctor makes a commitment to you for his time, special garments and implants have been ordered, and arrangements are made with nursing and anesthesia personnel to work on that date.**

**In order to reserve a date for your procedure, we ask that you pay a \$500.00 non-refundable "reservation fee". "Full payment" is due four weeks prior ("closing date") to the procedure in order to confirm the reserved time slot. If full payment is not received four weeks pre-operatively, the reserved date may be forfeited to another individual. The following rules apply to the full payment excluding the non-refundable \$500.00 reservation fee.**

1). There is no penalty if you cancel more than four weeks before surgery and have paid in full (excluding the reservation fee). There is no penalty if you cancel after the closing date due to illness and reschedule your procedure within 45 days. If you cancel between the closing date and two weeks before your surgery, **and do not reschedule within 45 days**, 10% of the total procedure cost will be withheld (surgeon's fee/anesthesia/facility) in addition to reservation fee of \$500.00. **In addition**, the cost of any implants, garments or special devices already purchased at the time of cancellation will be withheld. **Initials**\_\_\_\_\_

2). If you cancel in any of the two weeks before surgery **and do not reschedule within 45 days**, 25% of the total procedure cost will be withheld (surgeons fee/anesthesia/facility), in addition to the reservation fee. **In addition**, the cost of any implants, garments, or special devices already purchased at the time of cancellation will be withheld. **Initials**\_\_\_\_\_

3). If you cancel in any of the 3 days before surgery **and do not reschedule within 45 days**, 50% of the total procedure cost will be withheld (surgeon's fee/anesthesia/facility), in addition to the reservation fee of \$500.00. **In addition**, the cost of any implants, garments or special devices already purchased at the time of cancellation will be withheld. If you do not reschedule in 45 days, an additional \$300.00 charge will be added to cover the operating room personnel expenses by your initial cancellation the day of surgery. **Initials**\_\_\_\_\_

4) The balance of monies owed will be refunded within ten days after the cancellation unless you have rescheduled your procedure.

5). In the event that external collection services become necessary to obtain payment, you will pay all collection agency fees, returned check fees and attorney fees, as well as court costs associated with such collections. You agree that all attorney's and collection agency fees that do not exceed one-third of the account balance are reasonable and you agree to pay the same.

You will find that this goes beyond what other plastic surgeons offer and is spelled out clearly. I do my best to ensure your satisfaction as my patient and want your procedure to be a positive experience that you will tell your friends and family about. Please ask any questions to clarify the above policy.

**PLEASE NOTE THAT AN ADMINISTRATIVE FEE OF 5% WILL BE CHARGED FOR FILING CLAIMS TO YOUR INSURANCE CARRIER**

**I have read the above policy on revisions & cancellations and understand and agree to abide by it.**

Patient \_\_\_\_\_ Date \_\_\_\_\_

**THIS MUST BE SIGNED TO RECEIVE A WRITTEN QUOTE**

**Associated Plastic Surgeons, S.C.  
Otto J. Placik, M.D., F.A.C.S.**

**INSURANCE PAYMENT  
MEDICAL INFORMATION  
AUTHORIZATION**

I authorize the release of medical or other information to my insurance company and authorize payment of medical insurance benefits to be issued to:

Associated Plastic Surgeons, S.C.  
Tax ID# 36-2821079  
Otto J. Placik, M.D., F.A.C.S.

880 West Central Road, Suite 3100  
Arlington Heights, IL 60005

I permit a copy of this authorization to be used in place of the original. I agree to pay any remaining balance after insurance payment has been made.

**PLEASE NOTE THAT AN ADMINISTRATIVE FEE OF 5% WILL BE CHARGED FOR FILING CLAIMS TO YOUR INSURANCE CARRIER.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**WE ARE NOT A PARTICIPATING PROVIDER IN YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE CARRIER TO VERIFY THAT OUR SERVICES ARE COVERED UNDER YOUR SPECIFIC POLICY.**

\*\*\*\*\*

**PATIENTS UNDERGOING ELECTIVE COSMETIC SURGERY ONLY**

I have received the policies (PREVIOUS PAGE) regarding the elective surgery financial agreement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Associated Plastic Surgeons, S.C.  
Otto J. Placik, M.D., F.A.C.S.**

**AUTHORIZATION FOR RELEASE OF MEDICAL PHOTOGRAPHS/DIGITAL IMAGING**

Photographs are an important part of the medical record. These photographs are used to track your progress and response to surgery.

*BY SIGNING THE CONSENT BELOW, YOU WILL BE CONTRIBUTING TO OUR PHOTOGRAPHIC LIBRARY. YOUR SIGNATURE WILL ALLOW YOU THE PRIVILEGE OF VIEWING BEFORE AND AFTER PHOTOGRAPHS.*

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, and or digital imaging and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs and or digital imaging may be taken before, during or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography and or digital imaging for a stated purpose.

**CONSENT TO TAKE PHOTOGRAPHS/DIGITAL IMAGING**

I hereby authorize Otto J. Placik, M.D. and his associates or licensees to take pre-operative, intraoperative, and postoperative photographs, and or digital imaging. I additionally consent to photographs, and/or digital imaging of my interview.

**CONSENT FOR RELEASE OF PHOTOGRAPHS/DIGITAL IMAGING**

I hereby authorize Otto J. Placik, M.D. and or his associates or licensees to use pre-operative, intra-operative, and postoperative photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on electronic digital networks, television, for the purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_